

		FOR OFF USE					

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2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045294

Facility Name: PARKVIEW TERRACE

Address: 430 SOUTH 30TH AVENUE EAST MOLINE 61244  
Number City Zip Code

County: ROCK ISLAND

Telephone Number: ( 309 ) 755-3466 Fax # ( 309 ) 755-9144

IDPA ID Number: 36-4432316

Date of Initial License for Current Owners: 02/01/01

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:  
Name: BOB KAGDA Telephone Number: ( 847 ) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	MELVIN SIEGEL	
	(Title)	MEMBER	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
			(Date)
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	( 847 ) 675-3585	Fax # ( 847 ) 675-5777
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number PARKVIEW TERRACE

# 0045294 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>24</u>	Skilled (SNF)	<u>24</u>	<u>8,760</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>96</u>	Intermediate (ICF)	<u>96</u>	<u>35,040</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>3,436</u>	<u>3,436</u>	8
9	SNF/PED					9
10	ICF	<u>27,498</u>	<u>4,981</u>		<u>32,479</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,498	4,981	3,436	35,915	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.00%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 02/01/01

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 02/01/01 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number of beds certified 24 and days of care provided 3,436

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **PARKVIEW TERRACE** # **0045294** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	145,914	14,232	8,280	168,426		168,426		168,426			1
2	Food Purchase		143,830		143,830		143,830	(682)	143,148			2
3	Housekeeping	110,534	10,063		120,597		120,597		120,597			3
4	Laundry	35,785	14,377		50,162	113	50,275		50,275			4
5	Heat and Other Utilities			100,593	100,593		100,593	2,905	103,498			5
6	Maintenance	63,653		44,908	108,561		108,561	12,559	121,120			6
7	Other (specify):*			4,511	4,511		4,511	401	4,912			7
8	<b>TOTAL General Services</b>	355,886	182,502	158,292	696,680	113	696,793	15,183	711,976			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,239,973	61,472	10,170	1,311,615		1,311,615	14,040	1,325,655			10
10a	Therapy	27,508		3,187	30,695		30,695		30,695			10a
11	Activities	48,860	1,683	4,620	55,163		55,163	(4,620)	50,543			11
12	Social Services	41,467			41,467		41,467		41,467			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,357,808	63,155	29,977	1,450,940		1,450,940	9,420	1,460,360			16
	<b>C. General Administration</b>											
17	Administrative	92,018		112,000	204,018		204,018	3,721	207,739			17
18	Directors Fees											18
19	Professional Services			195,203	195,203		195,203	(145,811)	49,392			19
20	Dues, Fees, Subscriptions & Promotions			15,386	15,386		15,386	(2,841)	12,545			20
21	Clerical & General Office Expenses	74,850	7,504	42,844	125,198		125,198	65,223	190,421			21
22	Employee Benefits & Payroll Taxes			283,212	283,212		283,212		283,212			22
23	Inservice Training & Education							372	372			23
24	Travel and Seminar			8,467	8,467		8,467	11,268	19,735			24
25	Other Admin. Staff Transportation			13,971	13,971		13,971	7,129	21,100			25
26	Insurance-Prop.Liab.Malpractice			74,640	74,640		74,640	2,159	76,799			26
27	Other (specify):*			28,834	28,834		28,834	6,954	35,788			27
28	<b>TOTAL General Administration</b>	166,868	7,504	774,557	948,929		948,929	(51,826)	897,103			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,880,562	253,161	962,826	3,096,549	113	3,096,662	(27,223)	3,069,439			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	<b>DIETARY</b>		
	DIETITIAN CONSULTANT	XVIII B 35-2	8,280
	REPAIRS & MAINTENANCE		0
			0
			8,280
3	<b>HOUSEKEEPING</b>		
			0
			0
			0
4	<b>LAUNDRY</b>		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	<b>HEAT &amp; OTHER UTILITIES</b>		
	GAS HEAT		41,997
	ELECTRICITY		23,937
	WATER		33,993
	CABLE TV - LOBBY		666
			0
			100,593
6	<b>MAINTENANCE</b>		
	GROUNDS MAINTENANCE		2,361
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		39,925
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		720
	FIRE SERVICE		1,902
			0
			0
			0
			44,908
7	<b>OTHER</b>		
	SCAVENGER		4,106
	SECURITY SERVICE		405
			4,511
9	<b>MEDICAL DIRECTOR</b>		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000
			12,000

LINE		SCHED REF	TOTAL
10	<b>NURSING</b>		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B 47-2	8,970
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	450
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	GERIATRIC CONSULTANT	XVIII B 48-2	750
			0
			10,170
10a	<b>THERAPY</b>		
	PHYSICAL THERAPY SERVICES		668
	SPEECH THERAPY SERVICES		92
	OCCUPATIONAL THERAPY SERVICES		1,003
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	974
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	450
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			3,187
11	<b>ACTIVITIES</b>		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,620
			0
			4,620
12	<b>SOCIAL SERVICES</b>		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
13	<b>NURSE AIDE TRAINING</b>		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 112,000	112,000
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 15,168	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 27,553	
	BOOKKEEPING/ADMIN SERVICE	XIX C 152,482	195,203
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 2,372	
	EMPLOYEE WANT ADS	XIX F 2,149	
	CONTRIBUTIONS	VI 20 XIX F 380	
	DUES & SUBSCRIPTIONS	XIX F 5,099	
	LICENSES & PERMITS	XIX F 4,310	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 452	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 624	15,386
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	23,599	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 1,248	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	17,203	
	MESSENGER SERVICE	794	
		0	42,844

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 145,006	
	UNEMPLOYMENT COMPENSATION	XIX D 60,010	
	WORKERS COMPENSATION INSURANCE	XIX D 40,796	
	HOSPITALIZATION INSURANCE	XIX D 30,921	
	EMPLOYEE BENEFITS - OTHER	XIX D 6,479	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	283,212
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 2,458	
	TRAVEL	XIX G 6,009	
		0	
		0	8,467
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	13,971	13,971
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	74,640	74,640
27	OTHER		
	BAD DEBTS	VI 24 28,834	
			28,834

GRAND TOTAL COLUMN 3 OTHER 962,826

PARKVIEW TERRACE  
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
12/31/2005

TOTAL FOOD PURCHASE	143,830	PATIENT MEALS	107745
LESS SALES TAX	(682)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	143,148	TOTAL MEALS/YEAR	107745
TOTAL PATIENT CENSUS	35,915	NET FOOD	143148
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	107745
	-----		
TOTAL PATIENT MEALS	107745	COST PER MEAL	1.33
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			22,876	22,876		22,876	69,243	92,119			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,908	37,908		37,908	137,331	175,239			32
33	Real Estate Taxes			60,668	60,668		60,668		60,668			33
34	Rent-Facility & Grounds			271,386	271,386		271,386	(258,630)	12,756			34
35	Rent-Equipment & Vehicles			24,335	24,335	(113)	24,222	6,990	31,212			35
36	Other (specify):*											36
37	TOTAL Ownership			417,173	417,173	(113)	417,060	(45,066)	371,994			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		183,818	197,586	381,404		381,404		381,404			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		183,818	263,286	447,104		447,104		447,104			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,880,562	436,979	1,643,285	3,960,826		3,960,826	(72,289)	3,888,537			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,720)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(682)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,248)	21		18
19	Entertainment		20		19
20	Contributions	(832)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,834)	27		24
25	Fund Raising, Advertising and Promotional	(2,372)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,688)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,601)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (35,601)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (72,289)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47



NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49





VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MELVIN SIEGEL	49.00	ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	CONSULTING,
SUZANNE KOENIG	51.00	LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES LTD		BOOKKEEPING
		RIVER VIEW MANOR	LOVES PARK			
		SPRINGFIELD TERRACE	SPRINGFIELD			
		VANDALIA TERRACE	VANDALIA	PARKVIEW TERRACE		REAL ESTATE
		GOLDEN MOMENTS	JACKSONVILLE	PROPERTIES, LLC	SKOKIE, IL	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	PSYCH-SOCIAL CONSULTANT	\$ 4,620	MAVIN ENTERPRISES LTD		\$	\$ (4,620)	1
2	V	11	ACTIVITY CONSULTANT	4,620				(4,620)	2
3	V	19	ADMIN/BKKP. FEES	146,729				(146,729)	3
4	V								4
5	V								5
6	V	5	ELECTRICITY/GAS				2,905	2,905	6
7	V	6	MAINTENANCE SALARIES				12,527	12,527	7
8	V	6	MAINTENANCE & REPAIR				32	32	8
9	V	7	SCAVENGER				401	401	9
10	V	10	PSYCH-SOCIAL & NURSING CONSULT				18,660	18,660	10
11	V	17	ADMINISTRATIVE SALARIES				3,721	3,721	11
12	V	19	PROFESSIONAL FEES				918	918	12
13	V	20	ADVERTISING				363	363	13
14	Total			\$ 155,969			\$ 39,527	\$ * (116,442)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	TOTAL OFFICE	\$	MAVIN ENTERPRISES LTD		\$ 66,471	\$ 66,471	15
16	V	23	SEMINAR				372	372	16
17	V	24	TRAVEL				11,268	11,268	17
18	V	25	TRANSPORTATION				7,129	7,129	18
19	V	26	INSURANCE				2,159	2,159	19
20	V	27	EMPLOYEE BENEFITS				35,788	35,788	20
21	V	30	DEPRECIATION (SL)				584	584	21
22	V	32	INTEREST				1,685	1,685	22
23	V	34	OFFICE RENT				12,756	12,756	23
24	V	35	EQUIPMENT RENT				6,990	6,990	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 145,202	\$ * 145,202	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 271,386	PARKVIEW TERRACE PROPERTIES, LLC		\$	(271,386)	15
16	V	30	DEPRECIATION				71,379	71,379	16
17	V	32	INTEREST				135,646	135,646	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 271,386			\$ 207,025	\$ * (64,361)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6					SEE ATTACHED SCHEDULE						6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number      PARKVIEW TERRACE      #    0045294    Report Period Beginning:      01/01/2005      Ending:    2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☒      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization      MAVIN ENTERPRISES, LTD  
Street Address      3845 OAKTON  
City / State / Zip Code      SKOKIE, IL 60076  
Phone Number      ( 847) 679-0100  
Fax Number      ( 847) 679-0647

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY/GAS	PATIENT DAYS	143,350	7	\$ 11,595	\$	35,915	\$ 2,905	1
2	6	MAINTENANCE SALARIES	PATIENT DAYS	143,350	7	50,000	50,000	35,915	12,527	2
3	6	MAINTENANCE & REPAIR	PATIENT DAYS	143,350	7	128		35,915	32	3
4	7	SCAVENGER	PATIENT DAYS	143,350	7	1,602		35,915	401	4
5	10	PSYCH-SOCIAL & NURSING C	PATIENT DAYS	143,350	7	74,480		35,915	18,660	5
6	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	143,350	7	14,850	14,850	35,915	3,721	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	143,350	7	3,665		35,915	918	7
8	20	ADVERTISING	PATIENT DAYS	143,350	7	1,451		35,915	363	8
9	21	TOTAL OFFICE	PATIENT DAYS	143,350	7	265,310	218,673	35,915	66,471	9
10	23	SEMINAR	PATIENT DAYS	143,350	7	1,485		35,915	372	10
11	24	TRAVEL	PATIENT DAYS	143,350	7	44,974		35,915	11,268	11
12	25	TRANSPORTATION	PATIENT DAYS	143,350	7	28,456		35,915	7,129	12
13	26	INSURANCE	PATIENT DAYS	143,350	7	8,617		35,915	2,159	13
14	27	EMPLOYEE BENEFITS	PATIENT DAYS	143,350	7	142,843		35,915	35,788	14
15	30	DEPRECIATION (SL)	PATIENT DAYS	143,350	7	2,332		35,915	584	15
16	32	INTEREST	PATIENT DAYS	143,350	7	6,726		35,915	1,685	16
17	34	OFFICE RENT	PATIENT DAYS	143,350	7	50,915		35,915	12,756	17
18	35	EQUIPMENT RENT	PATIENT DAYS	143,350	7	27,901		35,915	6,990	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 737,330	\$ 283,523		\$ 184,729	25



IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	RELATED PARTY						\$		\$			\$	1		
2	PARKVIEW TERRACE PROPERTIES, LLC												2		
3	COLE TAYLOR BANK		X	MORTGAGE	\$23,967.98	4/05		3,945,468	3,296,317	4/08	6.0000	135,646	3		
4													4		
5	MGMT CO ALLOCATION											1,685	5		
	Working Capital														
6	COLE TAYLOR BANK		X	LINE OF CREDIT	DEMAND	02/11/04		364,633	522,561		PRIME+	37,125	6		
7	MB FINANCIAL BANK		X	BUSINESS LOAN	DEMAND	5/05						783	7		
8													8		
9	TOTAL Facility Related				\$23,967.98		\$	4,310,101	\$	3,818,878			\$	175,239	9
	B. Non-Facility Related*														
10													10		
11													11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$			\$		14	
15	TOTALS (line 9+line14)						\$	4,310,101	\$	3,818,878			\$	175,239	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																						
1. Real Estate Tax accrual used on 2004 report.				\$	<b>91,820</b> 1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	<b>75,865</b> 2																			
3. Under or (over) accrual (line 2 minus line 1).				\$	<b>(15,955)</b> 3																			
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<b>76,623</b> 4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND    \$    For    Tax Year.    (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<b>60,668</b> 7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:		2000	<b>67,107</b>	8	<table><tr><td colspan="3"><b>FOR OHF USE ONLY</b></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2004</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>	<b>FOR OHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2004	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>FOR OHF USE ONLY</b>																								
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
		2001	<b>71,461</b>	9																				
		2002	<b>74,385</b>	10																				
		2003	<b>90,911</b>	11																				
		2004	<b>75,865</b>	12																				
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL</b>																								
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.</b>																								

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates    RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

PARKVIEW TERRACE

COUNTY

ROCK ISLAND

FACILITY IDPH LICENSE NUMBER

0045294

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE ( 847 ) 675-3585

FAX #: ( 847 ) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	07-514-20-00	NURSING HOME	\$ 75,864.52	\$ 75,864.52
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 75,864.52	\$ 75,864.52

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    YES    X    NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

## X. BUILDING AND GENERAL INFORMATION:

**A. Square Feet:** 27,040 **B. General Construction Type:** Exterior BRICK Frame Number of Stories

**C. Does the Operating Entity?** ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

**(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)**

**D. Does the Operating Entity?** ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

**(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)**

**E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).**


**F. Does this cost report reflect any organization or pre-operating costs which are being amortized?** ☐ YES ☒ NO  
If so, please complete the following:

<b>1. Total Amount Incurred:</b>	<b>2. Number of Years Over Which it is Being Amortized:</b>

### 3. Current Period Amortization: 4. Dates Incurred:

**Nature of Costs:** \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

### A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		2005		\$ 2,770,922	\$ 71,379	27.5	\$ 71,379	\$	71,379	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	A-WING PAINTING & REFURBISHING OF RESIDENT ROOMS			2002	6,000	500	5	1,200	700	4,800	9
10	PAINTING & DECORETING			2003	30,000	10,000	5	10,000		20,000	10
11	INSTALL ALARM SYSTEM			2004	5,451	198	27.5	198		239	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$        2,812,373	\$        82,077		\$        82,777	\$        700	\$        96,418	70

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 15,763	\$ 2,242	\$ 1,577	\$ (665)	10 YRS	\$ 3,682	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	MGMT ALLOCATION		584	584				74
75	TOTALS	\$ 15,763	\$ 2,826	\$ 2,161	\$ (665)		\$ 3,682	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1998 FORD WINDSTAR	2004	\$ 16,050	\$ 5,136	\$ 3,210	\$ (1,926)	5 YRS	\$ 6,420	76
77	ADMINISTRATIVE	2001 LEXUS	2004	19,856	4,800	3,971	(829)	5 YRS	7,942	77
78										78
79										79
80	TOTALS			\$ 35,906	\$ 9,936	\$ 7,181	\$ (2,755)		\$ 14,362	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,864,042	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,839	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 92,119	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,720)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 114,462	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease .

9. Option to Buy: ☒ X YES ☐ NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: \$ 16,129 Description: SEE SCHEDULE ATTACHED  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	ADMINISTRATIVE	2001 LEXUS	680.13	8,206	18
19					19
20					20
21	TOTAL		\$ 680.13	\$ 8,206	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.



A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$			\$ 85,011	\$		\$ 85,011	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				11,662			11,662	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				100,913			100,913	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					152,183		152,183	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): MEDICAL SUPPLIES	39-2						31,635		31,635	13
14	TOTAL				\$		\$ 197,586	\$ 183,818		\$ 381,404	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 6,665	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	733,576		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,807		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	280,046		8
9	Other(specify): <u>REAL ESTATE TAX ESCROW</u>	47,691		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,126,785	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	41,451		15
16	Equipment, at Historical Cost	51,669		16
17	Accumulated Depreciation (book methods)	(64,746)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CONSTRUCTION ESCROW</u>	80,629		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 109,003	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,235,788	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 487,563	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,000		28
29	Short-Term Notes Payable	817,578		29
30	Accrued Salaries Payable	36,615		30
31	Accrued Taxes Payable (excluding real estate taxes)	86,712		31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,623		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,546,091	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,546,091	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (310,303)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,235,788	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (400,666)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(4)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (400,670)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	90,367	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 90,367	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (310,303)	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,928,495	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,928,495	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	122,698	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 122,698	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,051,193	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	696,680	31
32	Health Care	1,450,940	32
33	General Administration	948,929	33
	<b>B. Capital Expense</b>		
34	Ownership	417,173	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	381,404	35
36	Provider Participation Fee	65,700	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,960,826	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	90,367	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 90,367	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,984	2,080	\$ 60,307	\$ 28.99	1
2	Assistant Director of Nursing	1,984	2,120	38,151	18.00	2
3	Registered Nurses	7,033	7,433	140,685	18.93	3
4	Licensed Practical Nurses	19,341	21,153	331,017	15.65	4
5	CNAs & Orderlies	58,001	62,464	596,357	9.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,333	2,568	27,508	10.71	8
9	Activity Director					9
10	Activity Assistants	4,047	4,850	48,860	10.07	10
11	Social Service Workers	2,752	3,142	41,467	13.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,194	17,826	145,914	8.19	15
16	Dishwashers					16
17	Maintenance Workers	6,926	7,640	63,653	8.33	17
18	Housekeepers	14,003	14,849	110,534	7.44	18
19	Laundry	3,614	4,166	35,785	8.59	19
20	Administrator	2,024	2,120	92,018	43.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,229	5,645	74,850	13.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,793	1,938	39,166	20.21	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord</u>	1,984	2,080	34,290	16.49	33
34	TOTAL (lines 1 - 33)	149,242	162,074	\$ 1,880,562 *	\$ 11.60	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 8,280	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	450	10-3	39
40	Physical Therapy Consultant	L	974	10a-3	40
41	Occupational Therapy Consultant	Y	450	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,620	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHO-SOCIAL CONSULTANT</u>		8,970	10-3	47
48	<u>GERIATRIC CONSULTANT</u>		750	10-3	48
49	TOTAL (lines 35 - 48)		\$ 36,494		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.



**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7							N/A						
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$ 0	\$	\$	\$	\$	\$



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$4,611
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.    \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.    \$ 65,700  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.    \$ 0 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period.    \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period.    \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees